CITY OF TORONTO

DEPARTMENT OF PUBLIC HEALTH

DEPARTMENTAL PROGRAMS

POLICY PAPER

DEPARTMENTAL PROGRAMS SUBCOMMITTEE

SEPTEMBER, 1982

INDEX

	PAGE
PREAMBLE	(1)
MANDALA OF PUBLIC HEALTH (Figure 1)	2
A. A MODEL OF PUBLIC HEALTH	3
B. DEPARTMENTAL GOAL STATEMENT	5
INTERRELATIONSHIP OF DEPARTMENTAL PROGRAMS (Figure 2)	7
C. DEPARTMENTAL PROGRAMS IN PUBLIC HEALTH	8
1. Overview	8
2. Detailed Description	10
a) Health Information Programs	10
b) Health Promotion Programs	14
c) Health Protection Programs	16
d) Disease Prevention Programs	20
3. Implementation	26
D. CRITERIA FOR DEPARTMENTAL PROGRAMS	27
E. RANKING OF CURRENT PROGRAMS	32
F. OTHER ISSUES	34
1. Leading Force Strategy	34
2. Community Care and Support	35
3. Provincial Mandatory Programs	37
REFERENCES	38
APPENDICES	39

DEPARTMENTAL PROGRAMS - POLICY PAPER

PREAMBLE

The report Public Health in the 1980's gave as its two goals:

- "to establish a public health system which is self-regulating and responsive to continuing change";

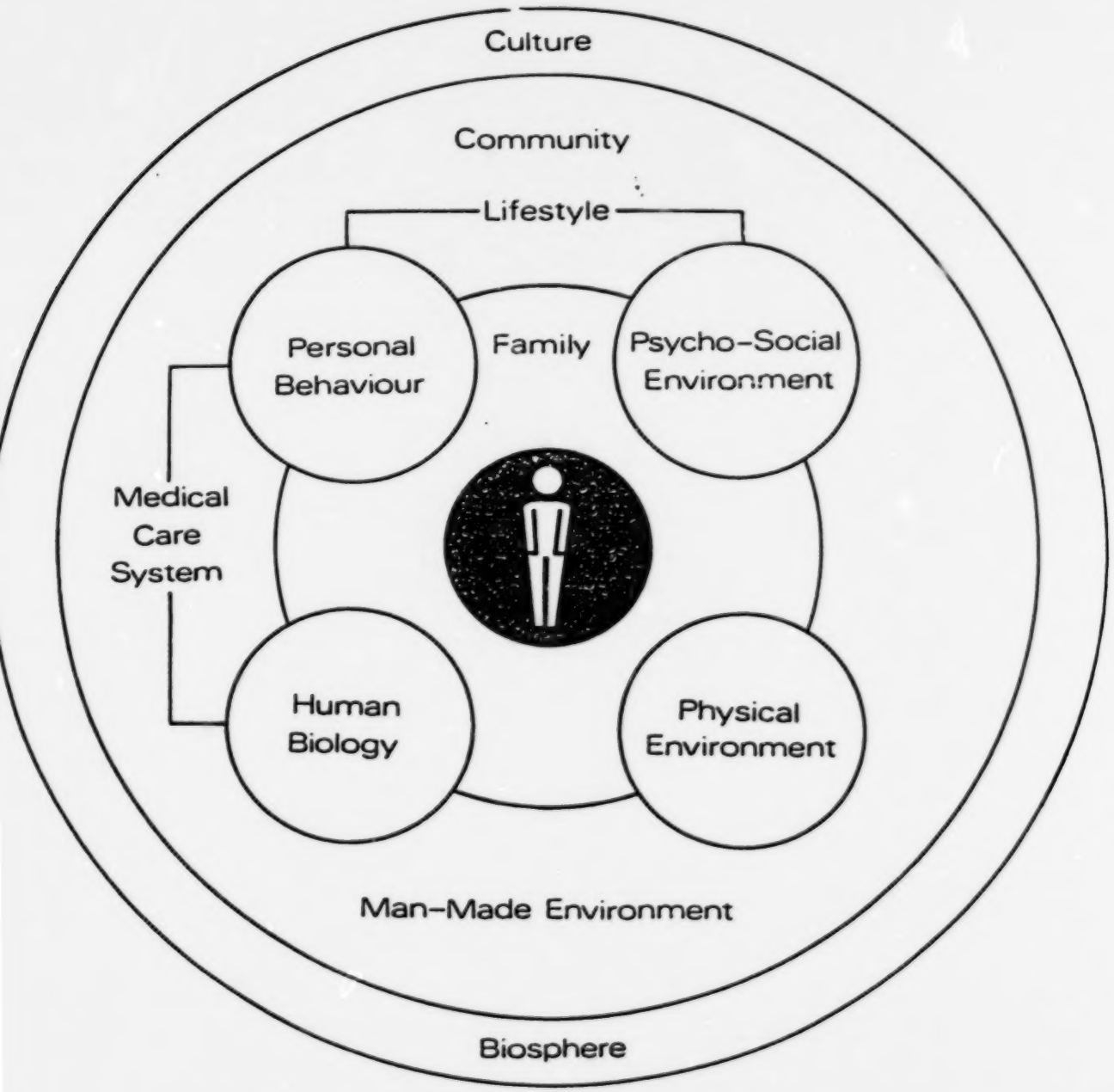
- "to build a Department which can resist the pressure to be all things to all people ... Roles proper to public health must be defined by policy, not through expediency".

This Policy Paper seeks to outline an approach to the creation of a self-regulating and responsive Department by defining roles proper to public health. The chosen approach has been to develop a theoretical basis for choosing Departmental programs, to develop a method for delineating such programs, to evaluate existing programs, to designate Departmental programs and to propose a framework for developing goals and objectives for such programs.

While the Ministry of Health is presently developing mandatory programs under the new Health Protection Act, the Local Board of Health has, in the past, expressed reservations about some of those programs which are not entirely compatible with Public Health in the 1980's. Accordingly, the Local Board of Health, at its meeting on July 22, 1980, endorsed "the ongoing development of the Department's own programs and standards consistent with Public Health in the 1980's, and based on goals and priorities established on the basis of informed research and community input."

The development of this Policy Paper over the past two years must be set in the context of the Department's restructuring. It was found that certain prerequisites for good program planning were lacking, and these have had to be developed by the Program Subcommittee. In particular, the Subcommittee has developed a model of public health which is gaining wide acceptance, and has developed a goal statement, a statement of philosophy and a definition of health. The Subcommittee also has developed a set of Departmental program criteria and a set of "deletion/dilution" criteria for ranking existing programs consistent with Departmental program criteria. Finally, the Subcommittee's initial working papers have been influential in shaping the reorganization of the Department.

FIGURE 1



THE MANDALA OF PUBLIC HEALTH

A. A MODEL OF PUBLIC HEALTH

The scope of public health is shown diagrammatically (Figure 1) in the public health mandala (a mandala is a circular symbol of the universe). At the centre is the individual, often as part of a family. The four major factors that affect the individual's health are human biology, personal behaviour, the immediate psychosocial environment (school, income, work, media, etc.), and the immediate physical environment (home, workplace, neighbourhood). "Lifestyle" is personal behaviour as influenced and shaped by the psychosocial environment and a lifelong socialization process. The medical care system is another factor affecting the individual's health, almost entirely through human biology and personal behaviour.

All of these factors operate within a community, with its social support systems, values and rules, and within a predominantly man-made environment, which includes housing, transportation, energy systems and the workplace.

This community is in turn part of a cultural system which is that of a western industrialized democracy with its value systems, political systems, and scientific/technological orientation. The man-made environment is contained within a local and planetary eco-system which includes the air, water, soil and all living things. Health or ill health is a product of the interaction of all these factors.

The mandala permits several levels of analysis. Firstly, all factors in the upper half of the mandala fall into the social sciences (psychology, sociology, anthropology, politics, economics, etc.) while those in the lower half fall into the natural sciences (physics, chemistry, biology, engineering, ecology, etc.), thus illustrating that public health is within the province of each of these major areas of human endeavor. It also unites the social and natural sciences or culture and environment, within a health framework. Indeed, since human ecology has been defined as the study of the interaction of culture and environment, public health can be seen as a model of the human ecosystem, comprising the social and cultural milieu and the natural and man-made environments.

Secondly, the relatively minor role of the medical care system as a factor in health is highlighted. Thirdly, the important mediating role of the family in dealing with adverse health impacts upon the individual is indicated. Fourthly, the model is a dynamic two-way model - the individual can impact upon her/his culture and environment, just as the culture and environment impact upon the individual. It is therefore a hopeful model in that it suggests that we can effect changes,

and to do so, we can apply two fundamental principles of public health, which are consistent with the mandala.

The first principle is based on the fact that ultimately we can be healthy only in a healthy world. At its most fundamental level, the recognition of this fact requires that we seek to maintain the balance of nature, that we promote the stability of the ecosystem and that we protect it from the harmful assaults of man. This principle is that of ecological sanity.

The second principle is that of social justice, which requires that we seek the greatest health for the greatest number, that we protect citizens that are at the highest risk for ill health, and that we act to remove the constraints which prevent individuals from attaining a higher level of health. We can be healthy only in a healthy society.

The unique perspective that public health offers is the realization that health is, of necessity, affected by all parts of the mandala. To be truly healthy, all the factors that affect health have to be in balance. If any of the areas of the mandala are out of balance then the individual, community or society are at risk for ill health. Public health workers must therefore be involved in applying the principles of ecological sanity and social justice to all aspects of the mandala.

Intervention by public health workers can be at any of three levels of society:

a) Individuals (personal responsibility).

b) Community (community responsibility).

c) Government (legislation, etc.)

The mandala helps us to understand the scope of public health, to understand the complexity and interrelationships of factors affecting health, and thus to correctly analyze the various intervention strategies needed to improve the public's health.

B. DEPARTMENTAL GOAL STATEMENT

The U.S. publication Model Standards for Community Preventive Health Services (which provides model goals, objectives, outcomes and indicators for preventive health programs) suggests that the first outcome indicator for the goal of effective and efficient administration is "an agency goal statement defining its philosophy, beliefs and purposes". Furthermore, a goal is defined as "a timeless statement of aspiration". The following mission statement represents a timeless statement of the aspirations of the Department.

> "THE MISSION OF THE CITY OF TORONTO DEPARTMENT OF PUBLIC HEALTH, IS TO MAKE TORONTO THE HEALTHIEST CITY IN NORTH AMERICA".

This statement immediately raises several issues. Firstly, what is health? We have defined health, somewhat idealistically, as:

> "A state of complete physical, mental, spiritual, social and ecological well-being, and not merely the absence of disease or infirmity".

Furthermore, we define well-being as:

> "A relative level of balance at which the individual is able to function optimally, given the constraints acting upon that individual".

In other words, we recognize that health is an idealistic state with many components, but that in the real world there are constraints which limit our ability to achieve this state. We aim, therefore, for the optimum.

The second issue raised is, how are we to measure the City's health? It is imperative that the Department develop the means to assess community health status on a regular and ongoing basis, and develop the tools to determine the impact of Departmental programs on health status.

A third issue is that the overall mission statement needs to be elucidated. The Department should develop a comprehensive set of lifecycle-based or program-based goals such as those developed in the U.S., but using the outcome-oriented format developed by the Vancouver Public Health Department (see Appendix 1 for an example).

A fourth issue is that, obviously, the Department is not solely responsible for the health of the City. Therefore, the

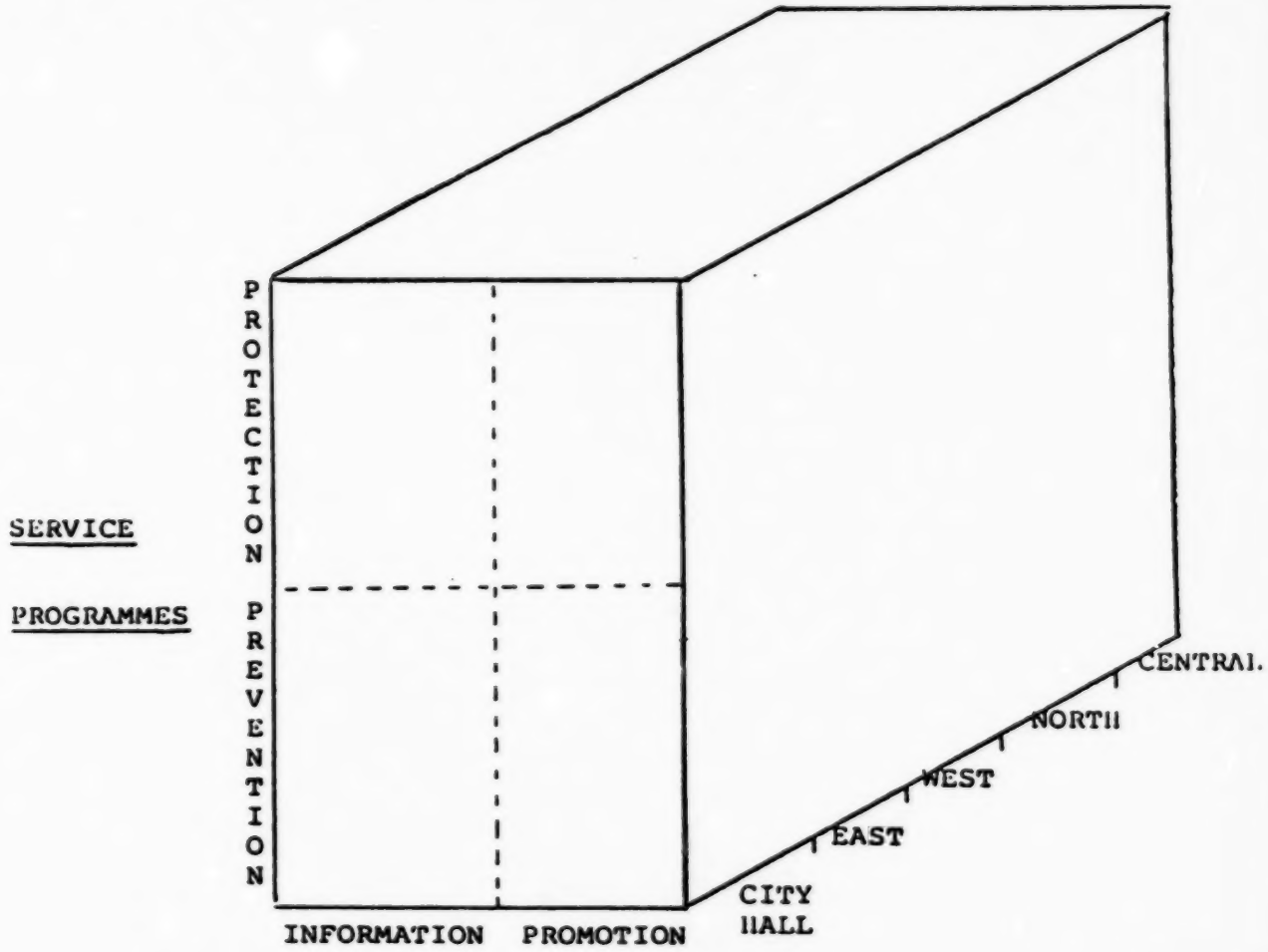
Department must work closely with, and support, any individual or group whose purpose is to improve or maintain the health of the citizens of Toronto in any way that is consistent with Local Board of Health policy.

A fifth issue that arose in our consideration of the mission statement led to the recognition that if the Department is to make Toronto the healthiest City in North America, it is crucial that the Department of Public Health become a leading force in the community, whether that community be the City of Toronto and its many neighbourhoods and ethnic groups, the wider community of Ontario and Canada and their political leaders, or the public health, environment and social justice movements locally, provincially, nationally or even internationally. If the Department is not able to attract the staff it needs, coordinate the resources it requires and influence others, both individuals and large institutions, it will not be able to accomplish its mission. It is imperative that the Department become both highly visible and highly credible to all its communities. Quite simply, if we are to make Toronto the healthiest City in North America, we must become the best Department of Public Health in North America. Some of the ways in which this can be achieved are addressed later.

Finally, of course, if we are to make the City the healthiest in North America, we need good programs. It is this need which the Departmental approach seeks to meet.

FIGURE 2

INTERRELATIONSHIP OF DEPARTMENTAL PROGRAMS



C. DEPARTMENTAL PROGRAMS IN PUBLIC HEALTH

1. Overview

The fundamental activities of public health have frequently been categorized as health promotion, disease prevention, and health protection. However, this ignores the vital importance of health status data, research evaluation and planning in modern health activities, as stressed in Public Health in the 1980's. Therefore, there will be four areas in which Departmental programs are developed:

Health Information
Health Promotion
Health Protection
Disease Prevention

The term "Departmental Program" applies to those programs which will be provided as a basic minimum in each of the Department's decentralized Health Areas and/or by the Central Resources Group. Other programs will be developed by the Health Areas to meet local needs.

1. Health information provides the basic epidemiological data and the research and analysis capability needed to plan, monitor and evaluate programs and to assess the state of health of the City.

2. Health promotion is complementary to both disease prevention and health protection, and has three components; health education seeks to change knowledge, attitude or behaviour, and is aimed at the individual, the family or small groups; health promotion seeks to create an awareness of need for change, and is aimed at the community at large; and advocacy seeks to create a climate supportive of change and is therefore aimed at other jurisdictions and other levels of government.

3. Health protection aims to protect the community as a whole from harmful environmental influences. It is therefore aimed at the community and the general environment, and seeks to prevent potential health problems from materializing.

4. Disease prevention is intended to prevent current major causes of death, disease and disability through three levels of preventive programs.

Primary prevention seeks to prevent the onset of disease, secondary prevention seeks to prevent the progression of disease, and tertiary prevention seeks to restore function once progression has been halted. Public health's major concern must be primary prevention.

A detailed description of Departmental programs in each program area follows after a brief discussion of some of the issues raised by the Departmental program approach.

The first of two Departmental program areas may be viewed as providing a support function which enables the programs in the other two areas (service programs) to be carried out. This is shown diagrammatically in Figure 2, which also indicates that Departmental programs, be they support or service in nature, may have different components in (and different implications for) central or decentralized parts of the Department.

i) "Support" versus "Service" Programs

Support programs are those which, in one way or another, facilitate the provision of services to the citizens of (and visitors to) Toronto. In broad terms, these two program areas provide the information necessary to plan programs, implement and monitor them, and evaluate them, as well as the technical expertise and resources needed to develop educational and promotional approaches and materials, to undertake community development and advocacy, and to ensure that staff are adequately trained and continually updated.

Service programs are those programs which provide direct service to the population in one way or another. They include specific individual services such as Healthiest Babies Possible, complaint responses, psychological counselling, or fluoride treatment, as well as more general services such as birth control education, food inspection, communicable disease control programs, etc. They will often, but not always, require varying degrees of support from some of the information or promotion programs.

ii) "Central" versus "Local" Programs

Without being categorical, it is likely that the support programs will be centrally based, whereas

the service programs will be locally based. This only makes sense, for the Central Resources Group should provide a consultative and support function in those areas where a high degree of expertise and specialization is required and where it would be redundant to provide that level of expertise in all four Health Areas. Conversely, Central Resources should not be providing direct services to the community.

iii) "Uniformity" versus "Flexibility"

Obviously, there is a need to develop some degree of uniformity in program delivery across the City, since Toronto's citizens have a right to expect to be treated fairly and equally, and to receive similar levels of service no matter where they live. Also, the Department (and the Ministry of Health) will need to be sure that uniform standards are being met, and City-wide outcomes achieved. On the other hand, the whole purpose of decentralization is to permit flexible programs responsive to local community need. The proposal for uniform programs does not conflict with the need for flexibility and local variation, if the outcome-oriented approach to program planning is adopted.

For example, the Department may have as its general outcome to attain 95% immunization City-wide. How each Area seeks to achieve that outcome will depend on the local situation: in one Area, a simple reminder letter to parents may suffice; in another Area immunization clinics might be needed. How any given outcome is attained will vary from Area to Area.

2. Detailed Description

a) Health Information Programs

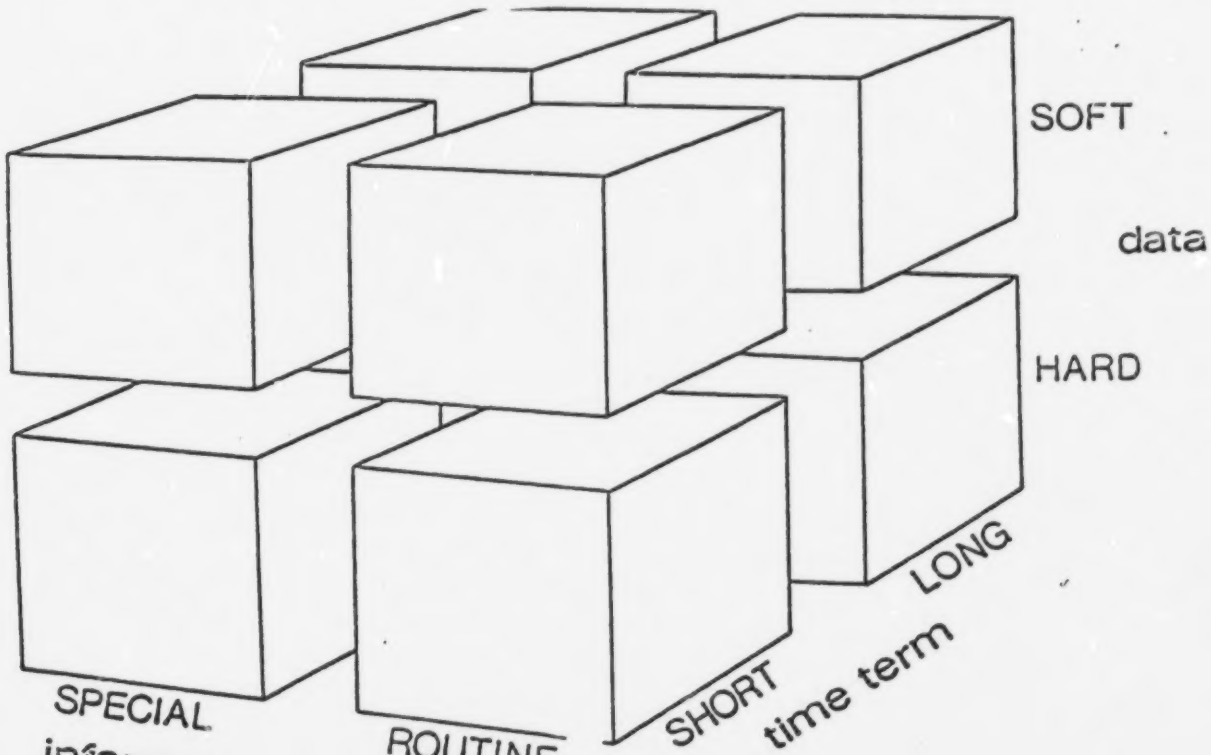
In order for the Department to adequately develop, monitor and evaluate programs in health promotion, health protection and disease prevention, the Department requires a sophisticated health information capability. The essential components of such a capability are:

i) Needs Assessment

The determination of community health needs is through the collection and analysis of data on all aspects of community health status. Such data, as described by New, et al, may be routine or special in nature, soft or hard in terms of quality, and long-term or short-term in duration (see Figure 1).

Examples of such data subgroups include:

- Routine, hard, long-term: vital statistics (births and deaths), hospital admissions and days.
- Special, hard, long-term: periodic community health surveys.
- Special, soft, short-term: local surveys of public perception of need.
- Routine, soft, long-term: venereal disease reporting.
- Special, hard, short-term: Health survey of suspected pollution incident.



ii) Research

In order to meet the many challenges of modern-day public health, the Department must be able to conduct reliable and reputable research into present and future health problems. Such research must be coordinated with research carried out by other health agencies (municipal, provincial and federal), academic institutions (University of Toronto, York University, Ryerson, etc.) and many other community groups (e.g., Pollution Probe, Ontario Welfare Council, etc.)

Research should be conducted at three levels, and wherever possible in a linked and coordinated manner. These three levels are:

- Policy analysis: examining the effects of present policy at municipal, provincial and federal levels and recommending appropriate changes;

- Project level: examining the relationships between specific health problems and specific factors that may be of concern;

- Reactive level: examining specific issues of concern to the Department, the Local Board of Health or the community.

Such research projects will need to be carried out in four general areas of concern:

- Disease/health entities: examples may include suicide, hypertension, smoking, childbirth, etc.;

- Physical environment: examples may include radiation hazards, pesticides, asbestos, indoor air quality, etc.:

- Social environment: examples may include poverty, ethnic communities, tobacco advertising, women's health problems, etc.; and

- Health care system: examples may include patient rights, prescribing of

medications, education of health personnel, provision of community care services, etc.

iii) Monitoring/Record Keeping

In order for the Department and its staff to be able to manage and administer programs, the various activities which staff undertake need to be monitored and appropriate records kept. It will be necessary to ensure that such information serves the dual purposes of administration and program management. It may be necessary to develop new forms and associated record-keeping systems to meet the Department's new needs, as was done for food and sanitation inspections.

iv) Evaluation

Evaluation has to become an important component of all programs in the Department. While it is sometimes important to seek to have all major programs evaluated by non-Departmental staff whenever possible, there will continue to be occasions when the Department will wish to perform its own evaluations. Obviously, the monitoring component outlined above will be important in this regard.

v) Planning

The planning process ties together needs assessment and research with program development and implementation and ensures that an evaluation process is being built in. The Department requires both a long-term strategic planning capability and a short-term program planning capability.

vi) Information Resource Centre

In order to keep up with the heavy flow of information on the very broad front of concern to the Department, and to enable the Health Areas to gain access to and utilize the information available both from within and outside the Department, an information resource centre will be needed. This resource centre should be linked up with the Department's

information exchange network proposed in the health promotion program area.

b) Health Promotion Programs

Departmental programs in the health promotion area are intended to create an awareness of the need for changes in knowledge, attitude and behaviour resulting in improved health, an environment conducive to such change and maintenance of that change in the long term. Such changes are needed not only in the community at large but within the Department itself and, in addition, the staff of the Department must develop the skills needed to conduct health promotion programs.

i) Health promotion as a specific program is the process of making the general public, or a specific sector of it, aware of the seriousness of a factor that reduces optimal health or of the nature of a disease-related factor, making them aware of the availability of assistance programs and reinforcing a learned message. While health promotion may lead directly to advantageous change, it is usually intended to create an awareness of the need for change and an environment conducive to change through more direct education strategies. Obviously, all health promotion efforts must take account of Toronto's multicultural nature.

ii) Health education is not merely the creation of awareness, but requires the presentation of specific information to a specific audience in such a manner that knowledge increases, and attitudes and behaviour may be changed. It is usually, therefore, a process targeted at small groups or individuals, and it must be presented in a linguistically and culturally acceptable manner.

iii) Health advocacy is a form of education intended to educate decision-makers about specific issues and move them towards political decisions expected to improve the health of the general public. While health promotion creates an environment conducive to positive health changes and health education provides the population with the incentive and the means to

change, health advocacy is intended to provide political support for healthier changes.

iv) Community development is an important part of health advocacy. It is the process of working with existing community organizations, through formal and informal bridging mechanisms, to create "grassroots" support for change and for the Department's activities. Where essential organizations do not exist it may be necessary to act as a catalyst to form an appropriate organization.

v) Staff development involves specific educational programs intended to develop and maintain the knowledge, attitude, behaviour and skills in the Department's staff needed to carry out the Department's programs. Such programs either may be developed in-house or through the use of outside resources. To develop an informed population, the Department requires an informed staff.

vi) Professional outreach refers to the conscious effort by the Department to communicate its point of view and its achievements to the rest of the public health movement locally, provincially, nationally or internationally. The purpose is to favourably influence the public health movement so as to create support for the Department's goals and thus more readily achieve these goals, as well as to share the results of the Department's work with similar organizations and individuals. Such outreach may be accomplished through the publication of articles, the presentation of papers and the education of students.

To summarize, the Departmental programs in health promotion should include:

Health education
Health advocacy
Community development
Staff development
Professional outreach

c) Health Protection Programs

Because the health problems addressed in the area of health protection are potential rather than actual, it is not possible to outline programs on the basis of existing epidemiological data. Instead, the Department must depend on a collective assessment of the factors most affecting the quality of the environment and the key preventive steps which can be taken to produce the greatest improvement. Such an assessment must also include, where possible, other program planning criteria such as early impact in the lifecycle and a priority on high risk groups. This approach, while not directly connected to immediate health indicators, recognizes the direct and indirect impact of environmental conditions on health. It is based on the assumption that improvements in the quality of the overall environment have important long-term positive impacts on the health of Toronto residents. Priority areas for Departmental programs in health protection were developed based on lengthy discussions and a Delphi type survey. The following list of priority concerns was developed:

1. Biological threats - pathogens, rodents, insects.

2. Workplace health threats.

3. Food quality.

4. Transportation, storage and disposal of chemicals.

5. Housing conditions.

6. Air quality.

7. Water quality.

Four additional criteria were applied in the process of incorporating these priority concerns into Departmental Health Protection Programs:

1. What is the Department legally responsible for?

2. What does the Department have expertise in?

3. What is the Department capable of?

4. How do these priorities fit into existing programs?

Using these criteria, five key program areas were identified:

i) Food quality control;

ii) Urban environment quality control;

iii) Communicable disease control;

iv) Pollution control;

v) Occupational health and safety.

A description of these programs is outlined below, but it should be noted that the program in communicable disease control was placed in the disease prevention group during the Department of Public Health Reorganization - Phase Two.

i) Food Quality Control

Inspection of premises where food is processed, stored, handled or kept for sale, for the purpose of enforcing proper hygiene standards. Specific examples are: food services at the Canadian National Exhibition, Ontario Place and other carnivals; other food serving premises (restaurants, boarding and lodging houses); community institutions (hospitals, daycare centres, nursing homes); retail food stores, wholesale food outlets, processing operations, and slaughter houses.

Investigation of food handling practices and, where appropriate, sponsoring educational sessions for people working in the premises described above, concerning proper procedures to employ in their work.

Public education and advocacy activities directed towards improving the nutritive quality of food sold in Toronto. Activities (in conjunction with disease prevention program activities) to include:

- promoting foods of higher nutritive value;

- advocating for less use of processing of foods;

- advocating to senior levels of government for stricter control over food additives both intentional (preservatives and food colours) and unintentional (pesticides, packaging materials).

ii) Urban Environment Quality Control

Inspection of public facilities for the purpose of enforcing appropriate sanitary conditions and health standards, with special attention to hospitals, day nurseries, hostels, schools, nursing and special care homes.

Response to complaints concerning unsanitary conditions, rodent or insect infestations and other nuisance conditions in food premises, public facilities, multi-occupant and single family dwellings.

Inspection and enforcement of public health standards in swimming pools, wading pools, whirlpools, saunas and bathing beaches.

Survey and inspect rental housing conditions, including sanitary and overcrowding problems, faced by low-income and other disadvantaged groups in Toronto and, where appropriate, advocate for improvements in housing conditions.

iii) Communicable Disease Control (this program was placed in the Disease Prevention Group for management purposes).

Achieve and maintain a high level of immunization in the community.

Investigate all cases of notifiable communicable diseases as appropriate, and take the necessary steps to limit the spread of such diseases.

Respond to requests from the public concerning communicable diseases and provide educational programs for the public as appropriate.

Investigate and ensure follow-up testing of all animals suspected of contacting rabies.

Conduct hospital infection control inspections as required, and work with hospital infection control committees.

Attend all disinterments and body shipments.

iv) Pollution Control

Ensure that a systematic year-round water sampling program of raw and finished Toronto water is maintained. The program should include regular testing for pathogens and toxic chemicals.

Ensure that year-round air monitoring sampling programs are conducted to test for general pollutants (SO2, NO, PAH, etc.). Identify the most important potential hazards and develop activities to reduce emissions from sources.

Ensure the appropriate monitoring and placing of emission controls on industries in areas of the City with greatest pollution problems.

Ensure that inspection and abatement programs are maintained to reduce the contaminants in the Toronto sewer system.

Ensure the proper regulation and monitoring of industries transporting, storing and disposing of toxic chemicals in the City.

Conduct sampling programs as may be required in response to complaints or to monitor health hazards in the community (e.g., asbestos in buildings, lead in soil).

v) Occupational Health and Safety

Provide to City employees and management occupational health and safety expertise in the establishment of health and safety programs.

Inspect industries in the City for the purpose of ensuring the safe handling and disposal of toxic materials.

Improve the overall expertise and experience of Departmental staff in the area of occupational health and safety.

d) Disease Prevention Programs

The major causes of mortality and morbidity were examined to determine which are amenable to a primary preventive approach, and to suggest what the Department's primary preventive programs should be. A committee of four persons (two physicians, one nurse, one psychologist) examined the data, and for each of the top ten causes of mortality and morbidity in the four main age groups (0-14, 15-44, 45-64, 65+), considered what primary and secondary preventive measures are available. The program implications of these measures were then considered and consolidated into a set of recommended Departmental programs, noting areas of special emphasis within each program where appropriate. For completeness, these program areas were then compared with the U.S. publication Healthy People, the Report of the Task Force on the Periodic Health Exam, Morgan's Prospects for Preventive Medicine and other suitable publications.

Before going further, however, three points must be stressed:

i) Common factors underlie many if not all major causes of ill health. These common factors relate in general to poor social conditions - inadequate income, poor housing, low socioeconomic status, over-crowding, ignorance and social instability - alienation, lack of social competence, family breakdown. While many primary preventive approaches are proposed, and many of these approaches should be targeted to such high risk groups, there is no question that if the Department is genuinely interested in preventing ill health it must seek to eradicate the underlying poor social conditions and social instability which so strongly predispose certain populations to excessive risk of ill health. Ensuring that Maslow's hierarchy of needs (physiological needs, safety needs, belongingness and affection needs, esteem needs and self-actualization needs) is met for all of the City's population may be the most important

target for the Department in its efforts to prevent ill health.

ii) Much physical and mental ill health has its roots in behavioural patterns and psychological coping mechanisms established in the first few years of life. If the Department is to have a reasonable impact upon the health status of the City, it will have to focus its preventive efforts on the period from conception (or just before) to early adolescence.

iii) The data is incomplete. Specifically, we presently lack good data on "community morbidity" - ill health in the community not seen in hospitals, or even by the health care system as a whole. To document this, we need to conduct a community health survey.

Having made these points, the following are the Departmental programs in disease prevention:

i) Family Planning (see also school health education)

- especially teenagers, second pregnancy
- multiparas
- women who may have high risk pregnancies.

ii) Preconception Health Education (see school health education)

iii) Prenatal Education

- nutrition
- tobacco, alcohol, drugs
- x-rays and medications
- prepared childbirth
- attachment
- breastfeeding

iv) Prenatal care

- Healthiest Babies Possible
- Early pregnancy registration

v) Parenting Education (see also school health education)

- creating competence in children
- managing minor illnesses
- immunization
- medications and x-rays
- accident prevention (especially seat belts)
- child management
- family stability/divorce

vi) School Health Education

- family life (including sex, family planning, parenting)
- lifestyle
- tobacco
- alcohol
- drugs
- nutrition
- dental

vii) Accident Prevention

- motor vehicle
- home
- recreational
- occupational

viii) Preventive Dentistry

- fluoridation
- preventive dental services
- nutrition

ix) Substance Abuse Control

- alcohol
- drugs

x) Stress Management

- stress reduction
- relaxation techniques

xi) Adult Health Education

- awareness
- behavioural change
- self-care

xii) Prevention of Iatrogenic Disease

- appropriate hospitalization
- appropriate surgery
- appropriate medications
- appropriate x-rays
- self-care/self-help groups

xiii) Screening Programs

(only if rigorously evaluated)

- children
- adults
- elderly

xiv) Community Support Networks (including assessment, early detection and monitoring)

- preschool
- children and adolescents
- elderly, risk retirement, bereavement, isolation
- mental health problems (psychoses, neuroses)

xv) Communicable Disease Control (described under health protection programs).

DISCUSSION

Parenting

A major component of ill health prevention concerns mental health in general, and the need to provide a supportive and stimulating environment for children. Time and again, we have found ourselves discussing the need for better parenting skills, and the need to intervene on behalf of children where those skills are missing or inadequate. While the latter process is to some extent undertaken by the Department, and ultimately is the responsibility of the Children's Aid Society, the means of developing better parenting skills is presently a neglected area. A number of different agencies, including the Department of Public Health, the Board of Education, Metro Social Services, Children's Aid, Child in the City, and the Ministries of Health, Education, and Community and Social Services should be interested in this area.

Medical Education

The possible role of the medical profession in contributing to mortality and morbidity was of concern to us. While we are all aware of Illich's criticism of iatrogenesis, perhaps we are less aware of Morgan's point that "prevention of iatrogenic disease is primary prevention." Iatrogenesis may be seen in many areas, including prenatally and in childbirth (viz. Report of the Task Force on High Risk Pregnancy), in unnecessary hospitalization (infant and child problems such as diarrhoea, respiratory infections, etc., and among the the elderly); in unnecessary surgery (tonsillectomy, hysterectomy, cholecystectomy) and in over-prescribing (tranquilizers, drugs

for the elderly, etc.). The role of the Department of Public Health is at present unclear, but the Department should play a role in seeking to reduce iatrogenesis. Possible activities include involvement in the education of medical students, continuing medical education and the support of self-care and self-help groups and movements.

Adult Health Education

This area is relatively downplayed in our proposals. Most of the Department's effort, as noted earlier, should be targeted on the early years in life. However, there may be a limited role for the Department in creating awareness among adults of their health problems (what they are, what can be done to prevent them, detect them and treat them), and perhaps in offering some behavioural change and self-care programs, where warranted.

Early Detection/Screening

While early detection through screening may be an important component of the preventive approach, screening has often been misused and abused. For example, general population screening for hypertension is probably not worthwhile in view of the poor follow-up and poor compliance, while scoliosis screening, glaucoma screening and vision screening remain controversial. While there may be some merit in some public health screening programs, the Department's role in screening needs to be carefully evaluated, and a start has already been made in reviewing childhood vision screening and scoliosis screening. No screening should be undertaken unless it meets the generally accepted criteria for screening.

Community Support Networks

The Department's role in providing what amounts to chronic care and support to people in the community must not be allowed to prejudice the more important task of primary prevention, though a case can be made that at least some of these care and support activities are secondary and even primary prevention. (A fuller discussion of the problems posed by the issue of community care and support is presented later).

3. Implementation

The Evaluation Task Force Report for the Eastern Health Area Reorganization recommended that each Health Area develop a set of program priorities within three months, and a set of "concrete and measurable objectives" for programs within six months. However, no attention was given to the context within which such priorities are to be assigned, or to the duplication of effort involved. It is important that the Department as a whole give some direction as to overall Departmental priorities before the Areas become too committed to courses of action which may be incompatible with Departmental priorities.

It is also important that the proposed outcomes be somewhat consistent and uniform across the City, and in a similar style. It would be a real saving if each Health Area did not have to re-invent the wheel in this regard. The Departmental Program Committees envisaged in the Department of Public Health Reorganization - Phase Two report have been formed and will be given the task of developing program priorities, as a means of establishing Departmental priorities. They will also establish standards and a uniform style of outcome statement, paying attention where appropriate to provincial mandatory programs as they are developed. Indeed, the Department will seek to provide extensive input to the development of provincial mandatory programs and standards.

In the somewhat longer term, these Departmental Program Committees will be responsible for monitoring and evaluating Departmental programs.

By having both Central and Area membership, these committees will ensure that the needs of the City as a whole, and of the Health Areas, are reconciled. Any unresolved problems would have to be resolved at the highest levels in the Department, and thus the committees will report directly to the Department Management Team.

D. CRITERIA FOR DEPARTMENTAL PROGRAMS

The development of Departmental programs for the City of Toronto Department of Public Health are to be based on the following criteria whenever possible.

a) Health Planning Criteria

1. Programs should have an epidemiological base.

2. Programs should have an impact as early in the disease process as possible (primary prevention is ideal).

3. Programs should have an impact as early in the lifestyle as possible.

4. Programs should be directed at high risk population.

b) Health Outcome Criteria (based on Sackett)

5. Programs offered by the Department should do more good than harm to those who accept them.

6. Efficacious programs should be accepted and used by the populations to whom they are offered (effectiveness).

7. Effective programs should be available and accessible to all those members of the population who could benefit from them (availability).

8. Effective programs should be made available in a way which optimizes the use of resources (efficiency).

Criterion 1 - Epidemiological Base

The first criterion for Departmental programs is that they be based upon epidemiological data. This requires that the Department be able to identify the major causes of mortality and morbidity affecting the citizens of Toronto and the major factors contributing to such mortality and morbidity. The Department also needs to be cognizant of actual or potential threats to the health of the City, and to be able to evaluate such threats, as well as to to be able to identify means of improving the health and well-being of the citizens. In addition, good

planning requires that the Department be able to measure the effect of its programs and evaluate program quality.

Criterion 2 - Impact Early in the Disease Process

Primary prevention, the prevention of a disease occurring, is the ideal basis for programming. However, in many instances it is not possible to prevent a disease from occurring either from lack of hard scientific knowledge of preventive measures, e.g., suicide, or the inability to eliminate the predisposing factors, e.g., asbestos.

If diseases cannot be prevented, then it is important that they be identified as early in the disease process as possible (screening).

Once a disease is identified, then programs should be developed to prevent further deterioration (secondary prevention) or to maximize rehabilitation (tertiary prevention).

Departmental programs should focus upon prevention and screening.

Criterion 3 - Impact Early in the Lifecycle

If a disease of childhood can be prevented by better prenatal care, then it is logical that the prenatal program be improved.

Immunization is started as early in the lifecycle as possible. Identification of developmental problems at a preschool age can have far reaching effects on the psychosocial development of a person.

Education for lifestyle may be more effective in the school-aged population than the adult population when habits are entrenched (e.g., smoking).

There are many program areas, however, that do not have impact in early life and where program intervention is more appropriate in adult life (e.g., health protection in the workplace, foot care for seniors).

Criterion 4 - High Risk Groups

High risk situations are those in which the physical or mental health of an identifiable individual or group of individuals is threatened. High risk situations range through the lifespan from preconception to death.

Disease and disability are not inevitable events to be experienced equally by all. Each of us at birth, because of heredity, socioeconomic background of parents or prenatal exposure, may have some chance of developing a health problem. But, throughout life, probabilities change depending upon individual experience with risk factors - the environmental and behavioural influences capable of provoking ill health with or without previous disposition.

It is tne controlability of many risks and often, the significance of controlling even only a few, that lies at the heart of disease prevention and health promotion.

Because risk factors interact in different ways, population groups which differ because of geographical location, age, and/or socioeconomic strata can experience substantial variability in disease incidence. Investigations of the variability can provide important clues about the extent to which major causes of disease and death may be preventable.

Examples of at risk groups can cross the life span, environment, socioeconomic groups or types of behaviour, e.g.:

High Risk Pregnancy - smoking, nutrition

High Risk Infant - heredity, birth process, socioeconomic status

High Risk Environment - asbestos in workplace

High Risk Behaviour - smoker, high speed driver

The Department should systematically identify high risk groups and develop programs to protect or promote the health of those groups.

Criterion 5 - Efficacy of Programs

Efficacy addresses the evaluative principle that a program should do more good than harm to those who accept the program and comply with the assessments, recommendations and treatments offered. In general, the Department would not be expected to be responsible for proving the efficacy of each program it offers, since such proof is dependent upon highly sophisticated research, including randomized controlled trials. However, the Department should ideally be able to produce evidence from the literature to indicate that the programs being offered are efficacious, and be willing to sponsor research when evidence is lacking.

Criterion 6 - Effectiveness of Programs

An efficacious program is of no value if it is not used by the population for whom it is intended. The extent to which the target population accepts and uses the program is a measure of its effectiveness. The Department must assess such issues as consumer satisfaction with a program and its staff, the acceptability of a program and the extent and duration of compliance. Special attention may need to be paid to high risk groups.

Criterion 7 - Availability of Programs

A program that is effective may still fail to achieve results if it is not available to the people for whom it is intended. Barriers to access to programs may be physical (e.g., no elevator), temporal (e.g., no evening programs), geographic (e.g., no transportation), financial, psychological, social or cultural, to name but a few. The Department will need to ensure that its programs are available and accessible to those who could benefit from them.

Criterion 8 - Efficiency of Programs

The efficiency principle assesses the best use of Departmental resources. Programs have to be analyzed for their worth compared to other programs that could be done with the same resources. If the resources to make a program available to those who could benefit from it are prohibitive, then a careful appraisal should be made of the program.

Resource efficiency can be applied to the prevention of certain diseases that are not common, but if not prevented are expensive in financial and human terms, e.g., PKU testing is efficient and effective compared with the treatment of this degenerative disease.

Manpower resources must also be assessed to ensure that highly skilled workers are available to be used to their potential. It is more efficient for a registered nurse to carry out the immunization program than a public health nurse or a doctor.

It is also more efficient for a clerk to do all the clerical work in the schools, rather than a public health nurse or registered nurse.

A shift in these two examples would free staff for work in programs more in line with Public Health in the 1980's, e.g., classroom teaching, group education and high-risk assessments.

In summary, efficiency addresses the question: "Is there a less costly way of providing this health program, and would scarce health resources spent on this program produce a greater health benefit if they were spent doing something else?"

E. RANKING OF CURRENT PROGRAMS

As one means of identifying those programs which the Department should consider dropping, a set of "deletion/dilution" criteria were developed. Based in part on program criteria, these criteria identify "weak" programs. The criteria are:

1. Not a major cause of mortality or morbidity
2. Not a primary preventive measure
3. Not targeted at a high-risk group
4. Not targeted early in the lifecycle
5. No legal requirements
6. No political demand
7. No community demand
8. A disproportionate use of time and resources
9. Duplicated effectively elsewhere
10. Inappropriate for the Department of Public Health.

These criteria were applied to all major programs and activities on a Divisional basis, using consensus within the Departmental Program Subcommittee.

The scoring on the score sheets (Appendix 2) was as follows:

x = meets a criterion

? = questionable

-- = inappropriate criterion

In our score sheets, the higher the score the "weaker" the program. For this reason the lists are in inverse priority, with the weakest program at the top. Two words of warning on interpretation are needed:

a) A "weak" program may not necessarily be considered for deletion or dilution. It may also be considered as one in need of strengthening; and a glance at the more detailed score sheets may provide some ideas for improvement.

b) It is probably best to confine comparisons to intradivisional rather than interdivisional comparisons.

While the judgments herein are necessarily subjective, we have tried to be fair, and always to have a broad cross-section of opinion. Divisions have had representation when their programs were under discussion. A comparison with the results of the same process applied to the Eastern Health Area (see their Program Priorities Report, May 1982) indicates broad agreement.

We have not considered Administration Services or (the former) Health Advocacy Unit programs, since our concern was with public service activities and not program support activities.

F. OTHER ISSUES

1. Leading Force Strategy

The need for the Department to become the best Department of Public Health in North America is a logical outcome of the mission statement. A number of aspects of such a leading force strategy are discussed below.

a) Accreditation

While no Departmental program in administration is proposed, the need for planning, monitoring and evaluating the administrative functions of the Department are obvious. Standards, goals and objectives are just as important in administration as in the Department's other programs. The Model Standards for Community Preventive Health Services contains seven pages of proposed standards for administration and supporting services, and many of the standards to be attained in the accreditation process refer to administrative functions.

The Department must become accredited by the Ontario Council for Community Health Agency Accreditation. Furthermore, the accreditation attained should be at the highest grade.

b) Teaching Health Unit

The Department must endeavour to become the principal teaching health unit for the Division of Community Health, University of Toronto. In addition, the Department should seek to become an important placement site for all public health professionals in training. The contribution that students and residents can make to the Department is considerable, and the Department also will benefit from helping to mould the next generation of public health workers.

c) Staff Development

The Department must make a significant effort to upgrade the calibre of its staff at all levels. Funds must be set aside to send staff on specialized training courses, and extensive in-house education must be developed. The maximal use of the Department's human resources is an important consideration.

d) Professional Outreach

If the Department is to influence the public health movement, its staff must be active members of that movement. Staff should be encouraged to join the various public health associations and organizations, and to be active in running these organizations. In addition, the presentation of papers or mounting of displays at meetings of the associations should be actively encouraged.

e) Publications

Staff should be encouraged to publish papers in the professional journals, and the Department should seek a means of ensuring that major reports and research studies are reported in the literature, preferably in peer-reviewed journals. In addition, the Department should widely disseminate important papers on a cost-recovery basis, and should consider advertising the availability of such reports in the Canadian Journal of Public Health.

f) Research

As the foregoing would imply, the Department must develop a strong research capability. Whenever possible, research projects should be linked with appropriate academic or community groups.

g) Coalitions

If the Department is to have an influence beyond the narrow confines of traditional public health and beyond the boundaries of the City of Toronto, it must join, or if necessary create, coalitions with like-minded groups in the environmental, social justice and related fields. Being a member of a coalition may require a certain level of commitment and support by the Local Board of Health, and a willingness to make a firm commitment and stand by it.

2. Community Care and Support

One of the major problems faced by the Department is the conflict, felt at all levels, between the main tasks, which are health protection, health promotion and disease prevention, and a host of other tasks which have fallen to our lot, which can be loosely described as community

care and support services. Such services include supportive home visits to senior citizens, discharged chronic patients, the disabled, and other disadvantaged groups.

It has been proposed that the Department has four broad responsibilities in the area of community care and support:

- to seek to create a more caring and supporting society through advocating for better and more coordinated services and a better social structure.

- to seek to create a more caring and supportive community through school and public education and the encouragement of community initiatives.

- to facilitate the provision of care and support services by community members by assisting informal support networks and perhaps by employing volunteer coordinators and using volunteers.

- to provide direct services, which include and are limited to screening and assessment, education and counselling of referred clients, monitoring where there is a goal of improving health status and referral to other appropriate community groups and agencies.

It is understandably difficult for staff involved in such activities to stop carrying them out; when someone is bleeding on the doorstep, one does not ignore them to perform less immediately urgent tasks such as primary prevention. Nonetheless, such activities are clearly not part of the mandate of public health, as the Local Board of Health has recognized in its report Public Health in the 1980's, in which it stated that:

> "Roles proper to public health must be defined by policy, not through expediency. The implication of this position is not the abandonment of real treatment needs in the community because they don't fit into Departmental policy, but rather the diversion of our limited energy toward the primary prevention of problems. The Department will, of course, continue to mobilize necessary service (treatment) programs to deal with urgent health problems - but in a gap-filling role only, and for a very limited program life. Given the goals and resources of public health, a one-to-one treatment

pattern (except on a short-term basis) is simply not feasible; moreover, maintenance of that pattern tends to maintain the problems. For example, public health nurses find themselves on an endless merry-go-round in finding sources of help for isolated, senile elderly people. Clearly, the problem exists on a societal level; we waste time, money, and effort trying to solve it on an individual level alone."

It is obvious, therefore, that a way must be found to ensure the provision of community care and support services without in any way compromising the ability of the Department of Public Health to carry out its primary preventive functions.

The current Local Board of Health/Department of Public Health Task Force on Services to the Elderly, and a newly created task force investigating the desirability and feasibility of using volunteers, will contribute greatly to this process. It is obvious that the Department and the Local Board of Health must shortly clarify the Department's policy and role in the light of ongoing developments related to chronic home care, services to the elderly, community psychiatric services and the use of volunteers.

3. Provincial Mandatory Programs

The Ministry of Health developed an initial outline of mandatory programs some time ago, but with the delay in finalizing the new Health Protection Act, it appears that they now intend to at least revise their previous proposals, and perhaps even to start again. In either case, an examination of their proposed service levels did indicate that, on the whole, we meet or exceed their requirements, though some areas of additional expense were noted in a report to the Local Board of Health (July 14, 1980). It is likely that our proposed Departmental programs will meet or exceed provincial requirements, but we must wait and see. It is important that we have a prominent voice in determining these provincial mandatory programs and their minimum standards, and that we develop our own program with an eye to provincial requirements as they emerge.

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APPENDIX I

OOM TERMINOLOGY FOR PROGRAM PLANNING AND EVALUATION

(VANCOUVER HEALTH DEPARTMENT, 1981)

PLANNING TERMINOLOGY

Mission:	The overall purpose of the Department of Public Health
Responsibility:	A specific function or area of responsibility which is derived from the mission. There are currently eight.
Program Area:	A grouping of several of the Department's programs. There are currently four.
Program:	A set of services and activities (see definition below) through which the Department's responsibilities are carried out. A program tends to focus on particular health problems or age groups, though the age boundaries are not rigid in practice. This developmental approach means that programs in any program area must consider age groups served as one aspect of the planning process.
Strategy:	A method or process by which a responsibility is carried out in a program. Several strategies may be considered in choosing services and activities to carry out the program.
Service:	A cluster of activities within a particular program; the actual elements or components of a program. These involve one or more disciplines, support staff, and resources.
Activity:	What a worker does. This is the foundation unit of behaviour for the OOM system. An activity can be observed and timed.

Local Board of Health November 9, 1982

EVALUATION TERMINOLOGY

General Outcome*:-
- A global statement of a desired condition.
- It is an expression of value held by the Department about healthful living.
- Is long range in its perspective.
- Says what is to be accomplished rather than saying what is to be done (focuses onresultsrather than activities or methods).

Specific Outcome:
- A more precise and concrete statement of desired direction for a general outcome, i.e., more, fewer, or maintenance of a direction.
- Is relatively short range in its perspective (e.g., 1-2 years)

Target Outcome:
- Includes three components:
- A time frame (usually one year or less with a specific date given)
- An indicator (the actual measurement instrument or technique used to gather evidence of performance)
- A numerical** value of the indicator (if the indicator is a percentage figure, the target would specify the level, e.g., 80% immunization level)

Example:

General Outcome 1.0

Babies are born healthy and thrive.

Specific Outcome 1.1

Fewer babies are born who weigh less than 2500 gm.

Target Outcome 1.11

95% or more of babies born to mothers attending prenatal classes in 1979 weigh 2500 gm. or more.

* General, Specific and Target Outcomes are presented for each program.

** Some indicators are more difficult to quantify than others. Proxy measures, including judgements and ratings, may be employed in some instances provided they are demonstrably related to the desired outcome.

DIVISION _____ C. D. C. & E.

PROGRAMME OR ACTIVITY	PLANNING					DELETION/DILUTION					SCORE			EVALUATION						
	Not Mortality/ Morbidity	Not Primary Prevention	Not High Risk Group	Not Early Life Cycle	No Legal Requirements	No political demand	No community demand	Disproportionate time/resources	Duplicated	Inappropriate	X	?	# Valid	Effacacious	Effective	Efficient	Available	Accessible	Programme Planning	
V. D. CONTROL		?		--							0	1	9							
T. B. CONTROL	X	?		--		?	X	X			3	2	9							
CHRONIC RESPIRATORY DISEASE PROGRAMME		X	--	X	X	X		X	X	X	7	0	9							

DIVISION DENTAL DIVISION

PROGRAMME OR ACTIVITY	PLANNING					DELETION / DILUTION					SCORE			EVALUATION					
	Not Mortality/ Morbidity	Not Primary Prevention	Not High Risk Group	Not Early Life Cycle	No Legal Requirements	No political demand	No community demand	Disproportionate time/resources	Duplicated	Inappropriate	X	?	# Valid	Efficacious	Effective	Efficient	Available	Accessible	Programme Planning
SCHOOL CLINICS		?			X						1	1	10						
HYGIENE CLINICS					X	X	?				2	1	10						
PRESCHOOL REGISTRATION		?	?		X	X		?			2	3	10						
NURSERY DAY CARE		?			X	X	X				3	1	10						
TOOTH FAIRY			?		X	X	X				3	1	10						
SURVEY TEAMS					X						1	0	10						
GERIATRIC PROGRAMME-- RUNNYMEDE HOSPITAL		X	X	X	X	X	X			X	7	(*delete)							

DIVISION FOOD & SANITATION

PROGRAMME OR ACTIVITY	PLANNING					DELETION/DILUTION					SCORE			EVALUATION					
	Not Mortality/ Morbidity	Not Primary Prevention	Not High Risk Group	Not Early Life Cycle	No Legal Requirements	No political demand	No community demand	Disproportionate time/resources	Duplicated	Inappropriate	X	?	# Valid	Efficacious	Effective	Efficient	Available	Accessible	Programme Planning
Environmental Monitoring				--	?				?		0	2	9						
C.D.C.				--			?	?			0	2	9						
Food Control				--							0	0	9						
General Sanitation	?			--							0	1	9						
Rodent Control	?			--							0	1	9						
Instituional Inspections				--							0	0	9						
Recreational Sanitation	X			--		?	?				1	2	9						
Meat Inspection				--							0	0	9						
Cockroaches	?	?	?	--				X		X	2	3	9						

DIVISION MEDICAL SERVICES

PROGRAMME OR ACTIVITY	PLANNING					DELETION / DILUTION					SCORE			EVALUATION					
	Not Mortality/ Morbidity	Not Primary Prevention	Not High Risk Group	Not Early Life Cycle	No Legal Requirements	No political demand	No community demand	Disproportionate time/resources	Duplicated	Inappropriate	X	?	# Valid	Efficacious	Effective	Efficient	Available	Accessible	Programme Planning
AUDIO PROGRAMME		?			X	X	X				3	1	10						
B.S.E.					X				X		2	0	10						
C.P.R.		X	--	--	X				X		3	0	8						
CARDIAC SURVEY	X	X			X	X	X	X		X	7	0	10						
COLOUR VISION SCREEN	X	X	X		X	X	X	X		X	8	0	10						
COMMUNICABLE DISEASE CONTROL		?		--					?		0	2	9						
EMPLOYEE HEALTH SERVICE	X	X	X	X			X	?	?	X	6	2	10						
HOME VISITS		X		X	X						3	0	10						
IMMUNIZATION					X			?	X		2	1	10						
OCCUPATIONAL HEALTH SVC.				X							1	0	10						
PRE-SCHOOL ASSESSMENT	X	?			X		?				2	2	10						
SCHOOL HEALTH: Medical Exams	X	X			X	X	X	X		X	7	0	10						
Scoliosis Screening	X	X			X	X	?	X		?	5	2	10						
Health Classes	?				X	X	X	?		?	3	3	10						
SCHOOL HEALTH COUNSELLING					X	X	X		?	?	3	2	10						
SPECIAL SCHOOL MEDICAL																			

DIVISION MENTAL HEALTH DIVISION

PROGRAMME OR ACTIVITY	PLANNING					DELETION/DILUTION					SCORE			EVALUATION					
	Not Mortality/ Morbidity	Not Primary Prevention	Not High Risk Group	Not Early Life Cycle	No Legal Requirements	No political demand	No community demand	Disproportionate time/resources	Duplicated	Inappropriate	X	?	# Valid	Efficacious	Effective	Efficient	Available	Accessible	Programme Planning
PRESCHOOL	?	X			X	X	X				4	1	10						
E.H. APPRAISAL	?	X			X	X	X				4	1	10						
HOME VISITING ASSESSMENT/COUNSELLING /ILL		X		X	X			X	X	X	6	0	10						
EXAMINATION, ASSESSMENT OF PATIENTS		X		X	X	?	X		X	X	4 6	1 1	10 10	(Edgar) (Fran)					
ADULT PROTECTION	X	X		X	X						4	0	10						
SCHOOLS				X	X	X	X	X			5	0	10						
SUICIDE PREVENTION				X	X	X	X				4	0	10						
CLUB		X		X	X	X	X				5	0	10						
CHRONIC CARE		X		X	X			X	X	X	6	0	10						

DIVISION NURSING

PROGRAMME OR ACTIVITY	PLANNING					DELETION / DILUTION					SCORE			EVALUATION					
	Not Mortality/ Morbidity	Not Primary Prevention	Not High Risk Group	Not Early Life Cycle	No Legal Requirements	No political demand	No community demand	Disproportionate time/resources	Duplicated	Inappropriate	X	?	# Valid	Efficacious	Effective	Efficient	Available	Accessible	Programme Planning
MATERNAL/CHILD Preconception	?		X		X	X					3	1	10						
Prenatal Classes			X		X			X	X		4	0	10						
Prenatal Home Visits					X						1	0	10						
Healthiest Babies P.					X			?			1	1	10						
Post Partum Classes			?		X		X			X	3	1	10						
Post Partum Visits			?		X						1	1	10						
Parenting (individual)		?			X	X	X		X	?	4	2	10						
Infant Health		?			X	X					2	1	10						
Preschool Screening					X						1	0	10						
Day Nursery Program						X	X				2	0	10						
First Aid in Schools	?	X	--	?	X		?	X	X	X	5	3	9						

DIVISION NURSING

PROGRAMME OR ACTIVITY	PLANNING					DELETION/DILUTION					SCORE			EVALUATION					
	Not Mortality/ Morbidity	Not Primary Prevention	Not High Risk Group	Not Early Life Cycle	No Legal Requirements	No political demand	No community demand	Disproportionate time/resources	Duplicated	Inappropriate	X	?	# Valid	Efficacious	Effective	Efficient	Available	Accessible	Programme Planning
SCHOOL HEALTH																			
C.D. Screening	?				X						1	1	10						
Pedic Screening	X	?			X			X		X	4	1	10						
Vision Screening	X	X			X	X	X		?		5	1	10						
I.C. Testing	?	X			?	X	X	?			3	3	10						
Scoliosis	X	X			X	X	X	?		?	5	2	10						
Early detection of all health problems		?			X	?			?		2	2	10						
Counselling	--				X	X	X		?	?	3	2	9						
ADULT HEALTH																			
B.S.E. Clinics				--	X				X		2	0	9						
Adult Screening		?	X	?	X	X	X				4	2							
Adult Health Individual		X		X	X	?		?		?	3	3	10						
Adult Health Group		?	?	X	X	?			X	?	3	4	10						
Placement/Monitoring	?	X		X	X			X		X	5	1	10						

POOR

QUALITY

ORIGINAL